

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041792

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10821

FILED NOV 7 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)

Park Lane

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

c. CITY

OR TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

d. STREET

ADDRESS

8604 Trafford LA

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

MARY STOLZ MAYER

4. DATE

OF DEATH

Month

Day

Year

Oct. 30 1963

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

3-21-1878

9. AGE (last birthday)

85

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (City and state or country)

Bohemia

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No None

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Leola Stewart 8604 TRAFFORD LA.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Empyema of the Gall Bladder

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Myocarditis

DUE TO (c)

585x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

20b. SUICIDE

☐

20c. HOMICIDE

☐

20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20e. TIME OF INJURY.

Hour a.m. p.m.

20f. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20g. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20h. CITY, TOWN, OR LOCATION

20i. COUNTY

20j. STATE

21. I attended the deceased from 10-26-63 to 10-30-63 and last saw her alive on 10-30-63

Death occurred at 7:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Frank J. Smith

22b. ADDRESS

4930 LINDELL BLVD

22c. DATE SIGNED

10-31-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

11-2-63

23c. NAME OF CEMETERY OR CREMATORY

St. Peters

23d. LOCATION (City, town, or county)

St. Louis Co. Mo.

23e. STATE

Mo.

24. FUNERAL DIRECTOR

JOHN STYGAR & SON

24a. ADDRESS

5541 RIVERVIEW BLVD.

25. DATE RECD. BY LOCAL REG.

OCT 31 1963

26. REGISTRAR'S SIGNATURE

Frank Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Em Rister*

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.